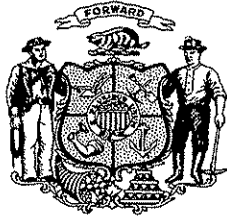


# STATE OF WISCONSIN

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## JOINT COMMITTEE ON FINANCE

### MEMORANDUM

To: Members  
Joint Committee on Finance

From: Senator Mark Miller  
Representative Mark Pocan

Date: December 22, 2009

Re: Department of Health Services Report of the Committee to Study  
Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)

Attached is a report on intermediate care facilities for the mentally retarded from the Department of Health Services, pursuant to 2009 Wisconsin Act 28, Stats.

The report was established pursuant to 2009 Wisconsin Act 28, the 2009-11 biennial budget bill, and was charged with studying the need for existing Intermediate Care Facilities for the Mentally Retarded in maintaining an effective, high-quality, planned system of services for person with developmental disabilities.

This report is being provided for your information only. No action by the Committee is required. Please feel free to contact us if you have any questions.

Attachments

MM:MP:jm



State of Wisconsin  
Department of Health Services

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Jim Doyle, Governor  
Karen E. Timberlake, Secretary

December 14, 2009

The Honorable Mark Pocan  
Assembly Co-Chair  
Joint Finance Committee  
309 East, State Capitol  
Madison, WI 53702

The Honorable Mark Miller  
Senate Co-Chair  
317 East, State Capitol  
Madison, WI 53702

Dear Representative Pocan and Senator Miller:

I am transmitting the Report of the Committee to Study Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) in Wisconsin. This Committee was established pursuant to 2009 Wisconsin Act 28, the 2009-11 biennial budget bill, and was charged with studying the need for existing ICFs-MR in maintaining an effective, high-quality, planned system of services for person with developmental disabilities.

The Committee found that Wisconsin has a strong long-term care system for serving people with developmental disabilities, with quality services both in institutional and in community-based settings. The Committee also concluded that the state needs an array of service capacities for people with developmental disabilities to both meet the range of needs across individuals and the varying needs a single individual may have over his or her lifetime. The Committee developed a set of recommendations designed to enhance the quality, access, and choice of long-term care services for persons with developmental disabilities in Wisconsin.

I wish to recognize and express appreciation to the members of this Committee for the time, energy, and thought that they devoted to this important issue.

Sincerely,

Karen E. Timberlake  
Secretary

**Report of the**  
**Committee to Study Intermediate Care Facilities**  
**for the Mentally Retarded (ICFs-MR)**

**December 2009**

## EXECUTIVE SUMMARY

In fall 2009, the Secretary of the Department of Health Services established a Committee to study Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) in Wisconsin, as directed in 2009 Wisconsin Act 28, the 2009-11 biennial budget bill. The committee was charged with studying the need for existing ICFs-MR in maintaining an effective, high-quality, planned system of services for persons with developmental disabilities.

As of November 2009, fifteen ICFs-MR operate in Wisconsin providing long-term care services to individuals with developmental disabilities. Of the fifteen, two are state-run centers, and thirteen are private or county-administered ICFs-MR. As of December 2008, a total of 884 individuals resided on a long-term basis in ICFs-MR in Wisconsin.

In Wisconsin and nationally, the number of ICFs-MR and the number of individuals with developmental disabilities residing in an ICF-MR have declined significantly over the last decade. The declines in the number of institutions and of institutional residents have been accompanied by an increased use of home- and community-based services for individuals with developmental disabilities. In Wisconsin, the number of individuals with developmental disabilities served in community settings almost doubled from 8,590 in 1999 to 15,655 in 2008, while the number of individuals with developmental disabilities served in institutional settings decreased by approximately two-thirds from 2,974 in 1999 to 945 in 2008. As a result, the proportion of individuals with developmental disabilities receiving publicly-funded long-term care services who were served in a community setting grew from 74% in 1999 to 94% in 2008. More individuals with developmental disabilities at each care level are served in the community than in an institution.

Wisconsin is in the lowest third of states in terms of the proportion of individuals with developmental disabilities residing in a long-term care institution; specifically, Wisconsin is one of 16 states where 10% or fewer individuals with developmental disabilities resided in an institution as of June 2007. States that have been most successful in transitioning to decreased use of ICFs-MR have developed community capacity in a planful manner either before or as relocations occurred. Wisconsin is committed to addressing the needs of each person with a developmental disability, whether in a community or institutional setting, using an individualized, person-centered approach.

The level of Medicaid reimbursement for non-state-administered ICFs-MR is set in the biennial budget bill. Similar to many other Medicaid provider groups, the full cost incurred by these institutions is not covered by the Medicaid reimbursement level. In contrast, Medicaid reimbursement for the State Centers fully funds the cost of operation. The state uses this approach to maximize the use of federal Medicaid matching funds to support the State Centers, thereby conserving the need for state funding.

Under Wisconsin law, an individual may be placed for long-term care in an ICF-MR only if a court finds the individual incompetent, appoints a guardian, and issues a protective placement order for an ICF-MR based on the finding that the facility is the most integrated setting appropriate to the individual's needs. The protective placement must be reviewed annually by the court.

The Committee's key findings are:

- Wisconsin has a strong long-term care system for serving people with developmental disabilities, with quality services both in institutional and in community-based settings.
- The state needs a range of service capacities for people with developmental disabilities to meet both the range of needs of individuals and the varying needs a single individual may have over his or her lifetime.
- To support people with developmental disabilities safely and successfully in the community, Wisconsin needs strong systems for specialized services that are accessible statewide, particularly in the areas of medical, psychiatric, dental, crisis intervention, and respite services.
- Given the increasing number and proportion of individuals with developmental disabilities who are choosing to live in community-based settings, Wisconsin needs to maintain a robust and adequately-funded community-based system.

## **RECOMMENDATIONS**

A majority of Committee Members supported the following recommendations:

- 1) Ensure that institutional and community settings meet the safety, medical, personal, social, and spiritual needs of an individual in an environment that fosters a sense of belonging, meaningful interaction and continued growth.
- 2) Expand specialized services, including short-term medical and behavioral services, dental services, crisis services, and respite services, to ensure these services are accessible statewide for individuals with developmental disabilities living in the community. A possible approach is developing capacity on a regional basis.
- 3) Leverage existing ICF-MR staff expertise to expand expertise and capacity in the community; for example, by training providers in the community.
- 4) Use staff and specialized services at the ICFs-MR, such as dental services, to serve individuals with developmental disabilities living in the community.

- 5) Ensure a capacity within the state for specialized long-term care for a period of time for people with developmental disabilities with complex medical acuity and behavioral and psychiatric needs.
- 6) Consider modernization of state DD Centers by building new, smaller, state-of-the-art buildings that are suitable for medically complex, frail individuals and that reflect best practices and contemporary standards that are community-oriented.
- 7) Ensure that information about short-term ICF-MR programs is known as an option for people on waitlists.
- 8) Provide short-term support for individuals and families on waitlists.
- 9) Develop strategies for improving retention of community-based caregivers.
- 10) Establish a parent forum, composed of parents of individuals living in both institutional and community-based settings, as a way of sharing information about the service array available for people with developmental disabilities.
- 11) Undertake a rigorous study of mortality rates in Wisconsin for people with developmental disabilities in both institutional and community settings to understand the relative mortality and safety risks in both settings.
- 12) Increase the Medicaid reimbursement rate at non-state ICFs-MR (for example, by reallocating funding that had previously been used for residents who die to increase the Medicaid ICF-MR reimbursement rate).
- 13) Ensure that institutional funds that are reallocated to the community remain sufficient to support fully individuals' needs.
- 14) Refine the ICF-MR reimbursement method to more accurately reflect the level of acuity of individuals with developmental disabilities.
- 15) Explore the possibility of using the same Medicaid reimbursement formula for state and non-state ICFs-MR.
- 16) Instruct DHS to conduct an internal review of its current oversight methods designed to ensure that people with developmental disabilities are living in the "most integrated settings," as required by state and federal law.
- 17) Instruct DHS to create a task force composed of state center staff, ICF-MR staff, and other knowledgeable people as appropriate to develop a plan to adapt programs and environments within state centers and ICFs-MR to best meet the needs of an aging population.

# **Report of the Committee to Study Intermediate Care Facilities for the Mentally Retarded (ICFs-MR)**

## **INTRODUCTION**

In fall 2009, the Secretary of the Department of Health Services established a Committee to study Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) in Wisconsin, as directed in Section 9122(7i) of 2009 Wisconsin Act 28, the 2009-11 biennial budget bill. This provision was initiated by the Legislature. As specified in statute, the committee was charged with “studying the need for existing intermediate care facilities for the mentally retarded in maintaining an effective, high-quality, planned system of services for persons with developmental disabilities.” The committee was composed of a broad range of stakeholders with interest and expertise in ICFs-MR. The full committee membership is provided in Appendix A.

The ICF-MR Committee met three times between October 6 and November 19, 2009. The Committee reviewed data and information from state and national sources and heard presentations from state and national experts in areas that the Committee determined were important to examine. The Committee expresses its appreciation to these resource experts for participating in this project. The Committee also recognizes and expresses its appreciation to Michael Pancook for his valuable contribution as staff to the Committee and for researching and compiling data reviewed by the Committee. The background section summarizes the material reviewed by the Committee.

## **BACKGROUND**

### *Institutions for Individuals with Developmental Disabilities*

Under Wisconsin statutes and regulations, an Intermediate Care Facility for the Mentally Retarded (ICF-MR) is a residential facility with the capacity to serve 4 or more individuals, which provides nursing care to any resident, and which primarily serves residents who are developmentally disabled and who require and receive active treatment. As of November 2009, fifteen ICFs-MR operate in Wisconsin providing long-term care services to individuals with developmental disabilities (see Appendix B). Of the fifteen, two are state-run centers and thirteen are private or county-administered ICFs-MR. The state operates a third ICF-MR, Northern Wisconsin Center, which as of September 2006 serves exclusively short-term intensive treatment program (ITP) clients. Two of the non-state facilities, Racine Residential Care and St. Coletta's of Wisconsin, Inc., are in the process of downsizing and intend to close in late 2009 or early 2010. Two other ICFs-MR, Southern Wisconsin Center and Bethesda Lutheran Communities, are restructuring by strengthening opportunities for voluntary relocations.

As of December 2008 (the most recent period for which detailed data is available), a total of 884 individuals resided on a long-term basis in ICFs-MR in

Wisconsin. Of this total, approximately half, or 447, resided in the two state Centers and the remaining half, or 437, resided in the county and private ICFs-MR (see Appendix C). The population of the private and county ICFs-MR ranged from 9 to 114, which was considerably smaller than the two State Centers, which served 184 and 257 long-term residents at Southern and Central Wisconsin Center, respectively (see Appendix B).

The number of ICFs-MR and the number of individuals with developmental disabilities residing in an ICF-MR have declined dramatically over the last decade (see Appendix C). Between 1999 and 2008, the number of non-state-owned institutions declined from 36 to 15 (representing a decrease of 58%); and the number of state-owned institutions serving long-term care residents decreased from 3 to 2 (representing a drop of 33%). Over that time, the total number of residents in ICFs-MR declined from 2,818 to 884, representing a decline of 69%. The decline in residents was sharper in non-state owned institutions, where the number of residents decreased from 1,920 in 1999 to 437 in 2008 (a decline of 77%). During the same period, the number of long-term care residents in state-owned institutions decreased from 898 to 447 (a decline of 50%). As a result of these population changes, as of 2008, state-run ICFs-MR began serving more individuals with developmental disabilities than non-state-owned ICFs-MR.

Long-term ICF-MR residents tend to be middle-aged, with an average age of 53 as of December 2008 (see Appendix D). The age of residents ranged from 9 to 97. Five residents of a non-state ICF-MR were under the age of 18 and three residents of a state center were under the age of 18.

In recent years, the number of long-term care admissions to ICFs-MR has declined (see Appendix E). Between 2005 and 2008, the number of admissions to a non-state ICF-MR decreased from 40 to 21 per year (a decline of 47.5%), and the state centers admitted no new long-term care residents. New admissions tended to be middle-aged, with an average age ranging from 42 to 48 in the 2005-2008 period. In each of these years, the number of deaths at the ICFs-MR exceeded the number of new long-term care admissions. Thus, the difference in the relative annual entry and death rates produces a decrease in the ICF-MR resident population. Any resident relocations that occur, due to downsizings, closures or other factors, contribute further to the decrease of the ICF-MR population.

#### *Wisconsin Utilization of ICFs-MR Compared to Other States*

The use of ICF-MR institutions varies widely among states (see Appendix F). In June 2007 (the most recent year for which comparative state data is available), Wisconsin operated 17 institutions. The average number of institutions per state was 126; and the median was 27. Maryland and Minnesota – states with comparable population sizes to Wisconsin – operated 4 and 291 institutions, respectively.

The size of institutions also varies considerably among states. As of June 2007, 4 of Wisconsin's institutions were between 7 and 15 beds; and 13 were 16 beds or larger. Maryland's 4 institutions were all 16 beds or larger. In Minnesota, the majority of

institutions (157) had 6 or fewer beds; 97 institutions had between 7 and 15 beds; and 37 institutions had 16 or more beds.<sup>1</sup> Nationally, 41.4% of individuals in an ICF-MR institution resided in a facility with 15 or fewer beds, whereas in Wisconsin, only 4.1% of ICF-MR residents live in a smaller facility.<sup>2</sup>

### *Relative Use of Community versus Institutional Settings for Individuals with Developmental Disabilities*

The declines in the number of institutions and of institutional residents have been accompanied by an increased use of home- and community-based services for individuals with developmental disabilities (see Appendix G). Wisconsin provides home- and community-based services through the Community Integration Programs (CIP 1A, CIP 1B), the self-directed supports waiver known as IRIS (Include, Respect, I Self-Direct), and the Family Care and Family Care Partnership managed long-term care programs.

The total number of individuals with developmental disabilities served in the publicly-funded long-term care system increased from 11,564 in 1999 to 16,600 in 2008 (an increase of 44%). During this period, the number of individuals with developmental disabilities served in community-settings almost doubled from 8,590 in 1999 to 15,655 in 2008, while the number of individuals with developmental disabilities served in institutional settings decreased by approximately two-thirds from 2,974 to 945. As a result, the proportion of individuals with developmental disabilities receiving publicly-funded long-term care services who were served in a community setting grew from 74% in 1999 to 94% in 2008.

Wisconsin's experience mirrors the national trend (see Appendix H). Since 1995, both Wisconsin and the nation transitioned from serving the majority of individuals with developmental disabilities in institutional settings to serving the majority in community settings. Throughout this time, Wisconsin has consistently served a lower percentage of individuals in institutional settings than the national average. In 2007, 20% of individuals with developmental disabilities nationally who receive publicly-funded long-term care resided in an institution compared to 7% in Wisconsin.

Wisconsin's use of institutions to serve individuals with developmental disabilities ranks among the lowest when compared to other states and Washington, DC (see Appendix I). Wisconsin is in the lowest third of states in terms of the proportion of individuals with developmental disabilities residing in a long-term care institution; specifically, Wisconsin is one of 16 states where 10% or fewer individuals with developmental disabilities resided in an institution as of June 2007. Ten states served a lower percentage of individuals with developmental disabilities in ICFs-MR than Wisconsin.

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<sup>1</sup> *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007*; College of Education and Human Development, University of Minnesota; August 2008; p. 60

<sup>2</sup> *Ibid*, p. 62

It is important to note that Wisconsin is committed to addressing the needs of each person with a developmental disability, whether in a community or institutional setting, using an individualized, person-centered approach.

#### *Acuity of Individuals in Community and Institutional Settings*

The following level of care categories are applied to individuals with developmental disabilities:

- *DD 1A*: individuals with fragile, unstable, or relatively unstable health status.
- *DD 1B*: individuals who require considerable guidance and supervision and who persistently or frequently exhibit behaviors directed toward self or others which may be dangerous to health and welfare.
- *DD 2*: individuals who exhibit appropriate social responses at most times, but may occasionally exhibit inappropriate behaviors. These individuals possess varying levels of functional abilities and their health statuses are usually relatively stable to stable.
- *DD 3*: individuals who exhibit appropriate social responses with rare incidents of inappropriate or maladaptive behaviors. These individuals' health statuses are stable.

The average acuity level within an ICF-MR institution is higher than the average acuity level of community-based individuals with developmental disabilities. In 2008, the majority of institutional residents were either DD 1A or 1B, with 85% of long-term care residents of state centers and 76% of residents at a non-state ICFs-MR at these levels (see Appendix J). As the population in ICFs-MR decreases, the average acuity level rises as the most medically complex, frail residents generally remain in the ICF-MR.

In contrast, 24% of members of community-based individuals with developmental disabilities in Family Care or Partnership in December 2008 were at the DD 1A or 1B levels, and the majority were at the DD 2 level of care. This indicates that in general, lower need individuals with developmental disabilities either never entered an institution or relocated from an institution to a community setting.

Although a greater proportion of individuals in institutions exhibit higher medical needs, more individuals at each care level currently reside in the community settings than in institutional settings. The difference between the size of the institutional and community populations at each level of care is even greater than shown in the data used for this analysis, as it does not include CIP 1A and 1B clients, who live in community settings.

#### *Legal Framework*

ICFs-MR are eligible for federal Medicaid reimbursement. Under federal Medicaid law, states are not required to cover ICF-MR services in a state Medicaid program; however, in practice, all states do. Some states do not provide ICF-MR services in-state, but fund ICF-MR services for their residents, if needed, in other states. A state Medicaid plan that covers ICF-MR services must do the following:

- require a written plan of care and regular independent professional review of each resident's need for ICF-MR services;
- provide for a utilization review program that screens each admission to an ICF-MR under criteria established by professionals not responsible for care of the resident and without financial interest in the facility;
- make these services available with reasonable promptness and provide methods relating to payment "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population;"<sup>3</sup>
- certify participating ICFs-MR as meeting federal requirements, including that each resident receive a continuous active treatment program.

States may provide services to individuals with an ICF-MR level of care outside of an institution and receive federal matching MA funds through home- and community-based waivers. Unlike funding for ICFs-MR, federal matching funds for the waiver programs do not cover room and board. If a state operates a home- and community-based waiver program, it must provide ICF-MR services as well and allow individuals and their guardians the right to choose between waiver and ICF-MR services. Wisconsin currently operates the following home- and community-based waiver programs for individuals with developmental disabilities at the ICF-MR level of care: the Community Integration Programs 1A and 1B, the IRIS self-directed supports program, the Family Care program, and the Partnership program.

The Americans with Disabilities Act (ADA) and state placement laws create a legal framework to protect the rights of individuals with developmental disabilities. ADA requires that a public entity shall administer services in the most integrated setting appropriate to the needs of qualified individuals with disabilities. The United States Supreme Court's *Olmstead* decision found that unnecessary institutionalization of individuals with disabilities could constitute discrimination under this provision of ADA. The *Olmstead* decision also recognized that the ADA does not require or condone terminating institutional settings for persons unable to handle or benefit from community settings.

Wisconsin placement laws establish further guidance on the appropriate use of institutions for providing services to individuals with developmental disabilities. An individual may be placed for long-term care in an ICF-MR only if a court finds the individual incompetent, appoints a guardian, and issues a protective placement order. These protective placements must be reviewed annually. The annual review process, known as a "Watts review," includes a county Adult Protective Services agency evaluation of the physical, mental, and social conditions of the individual. The initial or continued protective placement in an ICF-MR may occur only if the court finds that the facility is the most integrated setting appropriate to the individual's needs or that the county of residence "would not reasonably be able to provide" care under a community-based care plan "within the limits of available state and federal funds and county funds required to be appropriated to match state funds, taking into account information

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<sup>3</sup> SSA §1902(a)(30)(A)/42 USC §1396a(a)(30)(A)

presented by all affected parties.”<sup>4</sup> Under a court case known as the “Judy K.” case, the court found that a county must make a good faith effort to find and fund a community placement. State law defines the most integrated setting as one that enables the individual to interact with persons without developmental disabilities to the fullest extent possible. To ensure that an individual is in the most integrated setting, state law requires that the county of residence develop a community-based care plan that must be considered by the court as part of the annual Watts review process.

### *Rates and Funding*

Medicaid reimbursement for ICFs-MR is specified in the Medicaid State Plan and is based on four cost centers: (1) direct care, which includes direct care staff costs (nurses, nurse assistants, etc.) and direct care supplies and services; (2) support services, which includes dietary staff, housekeeping, laundry, administration, and utilities; (3) property taxes/municipal fees; and (4) property costs, which includes mortgage interest and depreciation. The nursing home reimbursement formula also includes incentive payments for certain outcomes. Medicaid payments to ICFs-MR are composed of approximately 60% federal Medicaid funds and 40% state general purpose revenue (GPR).

The level of Medicaid reimbursement for non-state-administered ICFs-MR is set in the biennial budget bill. Similar to many other Medicaid provider groups, the full cost incurred by these institutions is not covered by the Medicaid reimbursement level (see Appendix K). The estimated average Medicaid deficit for a non-state ICF-MR in state fiscal year 2008-09 was \$104.58 per patient day, which represents 32% of the total average cost per day. ICFs-MR must offset through surpluses in other lines of business or other funding sources, such as Foundation funding.

In contrast, Medicaid reimbursement for the State Centers is cost-based and the Medicaid reimbursement fully funds the cost of operation. The state uses this approach to maximize the use of federal Medicaid matching funds to support the State Centers, thereby conserving the need for state GPR funding. Any portion of the cost of the State Centers that is not reimbursed through Medicaid would need to be paid 100% with state GPR funding. The Department has submitted and received approval for a federal cost allocation plan, which allows a portion of indirect costs incurred at the Department to be allocated to the State Centers and included in the Center Medicaid reimbursement rate. This approach enables the state to claim all allowable federal Medicaid funding, and thereby minimizes the use of scarce state funding resources.

The state Medicaid reimbursement level also does not fully cover the cost of services in the CIP 1A and 1B waiver community-based programs for individuals with developmental disabilities. For these programs, counties provide the balance of funding needed to cover the cost of services (see Appendix L). With respect to the CIP 1A program, counties contributed \$7.27 million in 2006, \$7.18 million in 2007, and \$5.43 million in 2008. Over these years, the county contribution accounted for 7-8% of funding

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<sup>4</sup> Wis. Stat. § 46.279(2)

for CIP 1A participants. The CIP 1B program uses a combination of state-funded and county-funded slots. Based on December 31<sup>st</sup> caseloads for 2006, 2007, and 2008 and the October 30<sup>th</sup> caseload in 2009, over two-thirds of participants in this program are supported through county-funded slots. The county funding for these slots plus the supplementary county funding used to cover the full cost of state-funded slots totaled \$88.9 million in 2006, \$91.9 million in 2007, and \$78.6 million in 2008. Over these years, county funds comprised 31-35% of funding for this program. For both of the CIP programs, counties contributed \$96.2 million in 2006, \$99.0 million in 2007, and \$84.0 million in 2008, which represented 26-28% of the funding for the programs. Under the ICF-MR Restructuring Initiative, begun in January 2005, the state fully funds the community-based costs of individuals who relocate from ICFs-MR, thereby averting the need for county funding to help support these individuals.

The costs of serving individuals with developmental disabilities in institutions and in community settings differ (see Appendix M). In 2008, the estimated average cost of an individual in a state center, including Medicaid card services such as personal care, therapies, and medical equipment, was \$666 per patient day. The estimated average cost in a non-state ICF-MR was \$341 per patient day. Based on DHS's *SFY 2008 Report on Relocations and Diversions from Institutions*, individuals relocating from a non-state ICF-MR to a community setting incurred \$260 per day in Medicaid waiver and card service costs, on average. Prior to relocation, the average Medicaid expenditure for these individuals while in the ICF-MR was \$203 per day. The average Medicaid expenditure for these individuals while in an ICF-MR, \$203/day, differs from the average cost of these services, \$341/day, because as noted above, Medicaid payments for ICF-MR care do not fully cover the cost of the services.

#### *Services for Individuals Residing in the Community*

A range of residential and other services support individuals with developmental disabilities who live in the community. Community-based residential capacity in Wisconsin for individuals with developmental disabilities has grown significantly over the last decade (see Appendix N). Individuals with developmental disabilities may reside in Community Based Residential Facilities (CBRFs), Adult Family Homes (AFHs), a family member's home, or their own home or apartment. Between 2001 and September 2009, capacity of Community Based Residential Facilities (CBRFs) serving individuals with developmental disabilities, which serve five or more persons, increased from 4,542 to 4,907, which represents an increase of 8%. During that time, capacity of Adult Family Homes (AFHs) serving three or four persons with developmental disabilities doubled from 2,219 to 4,404. Data was not available to the Workgroup on the capacity and growth trends of smaller Adult Family Homes serving one or two persons.

Individuals with developmental disabilities may utilize specialized crisis or behavioral services periodically. The three State Centers operate short term intensive treatment programs (ITPs) that provide these types of services for individuals with long-term community-based living arrangements. The majority of individuals participating in these short-term services are at the DD 1B level of care and require treatment for

behavioral challenges (see Appendix O). The Centers operate the following short-term programs:

- Northern Wisconsin Center's EXCEL is a short-term, comprehensive evaluation and treatment program with 30 beds which serves children and adults with dual diagnoses of a developmental disability and mental illness. Between February 2003 and November 2009, the program had 184 admissions.
- Southern Wisconsin Center's 17-bed ITP provides short-term, intensive treatment for people with challenging behaviors, medical and/or nursing conditions, or other conditions in order to return individuals to a community setting as soon as possible. Between January 1992 and November 2009, the program had 174 admissions.
- Central Wisconsin Center operates two programs. The Short Term Assessment Program (STAP) is designed to meet the unique needs of children and adolescents with mild to profound developmental disabilities combined with significant behavioral challenges and/or psychiatric needs. Adults may receive program services as well. The Medical Short Term Care Unit (MSTCU) provides evaluation, consultation, and treatment for children and adults residing in the community. Between January 2003 and November 2009, the two programs had 189 admissions.

The average length of stay varies among the programs at the different Centers. The median length of stay for participants in Central Wisconsin Center's programs was 28 days in each of the last five years. Northern Wisconsin Center short-term service clients experienced median lengths of stays in the range of 3 to 4 months between 2005 and October 2009. The median lengths of stays at Southern Wisconsin Center varied significantly – between 87 days in 2008 and 306 days in 2006 – and tended to be longer than the other Centers. The statistics for Southern Wisconsin Center may be strongly influenced by outliers as the program served fewer patients in most years than did the other Centers' programs.

Another important specialized service for people with developmental disabilities is dental services. Due to their disabilities, individuals living in the community may pose unique challenges to community-based dental providers, which can affect access to these services. Data from state long-term managed care programs indicates that individuals with developmental disabilities experience dental access challenges, but that these challenges are similar to those faced by Medicaid clients generally. Of Family Care members with a developmental disability active on December 31, 2008, 47.8% had used a dental service in 2008. Of 2008 PACE/Partnership members with a developmental disability, 28.6% used a dental service during the year. In comparison, a slightly lower percentage, 25.8%, of other Medicaid and BadgerCare recipients received dental services in 2007. State experts in the area of dental services note that the biggest barriers to increased access are: (a) limited number of dental clinics with the physical capacity and design to accommodate people with developmental disabilities and (b) limited competency of dentists in serving people with developmental disabilities.

### *Use of Institutions in Long-Term Managed Care Programs*

Family Care, Family Care Partnership, and PACE, the state long-term managed care programs, cover services provided both in institutions and in the community. These programs use institutional services to a very limited extent for their members (see Appendix P). Of the 6,347 individuals with a developmental disability enrolled in Family Care on December 31, 2008, only 27 had stayed in either a State Center or non-state ICF-MR in the prior year while enrolled in the program. On December 31, 2008, eleven individuals, representing 0.2% of all members with a developmental disability, resided in an institution. Of the 325 individuals with a developmental disability enrolled in Family Care Partnership or PACE, none had stayed in a State Center or non-state ICF-MR in the prior year while enrolled in the program. However, the data on Family Care Partnership and PACE members may be artificially low as 2008 was the first year these programs began enrolling individuals with developmental disabilities.

### *Experiences in Other States*

As noted above, there has been a decreased reliance nationally on ICFs-MR to serve individuals with developmental disabilities. Charles Mosely, a national expert with the National Association of State Directors of Developmental Disabilities, briefed the Workgroup on experiences in other states. In a recent survey, 24, or approximately half of all states, indicated that they have plans to close and/or downsize public ICFs-MR in the state. Strategies that states use to reduce ICF-MR capacity include: (a) freezing admissions; (b) reducing the number of state-run centers through consolidation; (c) changing the roles of state-run centers to deliver medical and/or dental services to community-based individuals with developmental disabilities; (d) using state ICF-MR staff to train community-based providers as a means of expanding community capacity; and (e) developing community-based service capacity.

Most states have relied on group homes, such as adult family homes, rather than small ICFs-MR, to serve individuals relocating from large ICFs-MR due to the greater regulatory flexibility accorded group homes. A number of states have maintained ICFs-MR to serve individuals with dual mental health/developmental disability diagnoses. One of the community-based service capacities that is critical is emergency response crisis capacity.

A successful model used in some states is the establishment of regional centers for psychiatric and/or crisis intervention services for individuals with developmental disabilities. States that have been most successful in downsizing ICFs-MR have developed community capacity in a planful manner either before or as relocations occurred. States that can be considered possible models are: Vermont, Pennsylvania, Arizona, Ohio, Washington, and New Mexico. A useful guiding principle for states is that the quality of services for an individual who relocates to a community setting should be at least as good as the quality of services the individual received in his/her institutional setting.

## FINDINGS

Based on its review of the information in the areas noted above, the Committee identified the following key findings:

- Wisconsin has a strong long-term care system for serving people with developmental disabilities, with quality services both in institutional and in community-based settings.
- The state needs a range of service capacities for people with developmental disabilities to meet both the range of needs of individuals and the varying needs a single individual may have over his or her lifetime.
- To support people with developmental disabilities safely and successfully in the community, Wisconsin needs strong systems for specialized services that are accessible statewide, particularly in the areas of medical, psychiatric, dental, crisis intervention, and respite services.
- Given the increasing number and proportion of individuals with developmental disabilities who are choosing to live in community-based settings, Wisconsin needs to maintain a robust and adequately-funded community-based system.

## RECOMMENDATIONS

The following recommendations received the support of a majority of the Committee Members, that is, at least 8 votes in support of the recommendation. A summary of the voting and all comments related to the voting is provided in Appendix Q.

- 1) Ensure that institutional and community settings meet the safety, medical, personal, social, and spiritual needs of an individual in an environment that fosters a sense of belonging, meaningful interaction and continued growth.
- 2) Expand specialized services, including short-term medical and behavioral services, dental services, crisis services, and respite services, to ensure these services are accessible statewide for individuals with developmental disabilities living in the community. A possible approach is developing capacity on a regional basis.
- 3) Leverage existing ICF-MR staff expertise to expand expertise and capacity in the community; for example, by training providers in the community.
- 4) Use staff and specialized services at the ICFs-MR, such as dental services, to serve individuals with developmental disabilities living in the community.

- 5) Ensure a capacity within the state for specialized long-term care for a period of time for people with developmental disabilities with complex medical acuity and behavioral and psychiatric needs.
- 6) Consider modernization of state DD Centers by building new, smaller, state-of-the-art buildings that are suitable for medically complex, frail individuals and that reflect best practices and contemporary standards that are community-oriented.
- 7) Ensure that information about short-term ICF-MR programs is known as an option for people on waitlists.
- 8) Provide short-term support for individuals and families on waitlists.
- 9) Develop strategies for improving retention of community-based caregivers.
- 10) Establish a parent forum, composed of parents of individuals living in both institutional and community-based settings, as a way of sharing information about the service array available for people with developmental disabilities.
- 11) Undertake a rigorous study of mortality rates in Wisconsin for people with developmental disabilities in both institutional and community settings to understand the relative mortality and safety risks in both settings.
- 12) Increase the Medicaid reimbursement rate at non-state ICFs-MR (for example, by reallocating funding that had previously been used for residents who die to increase the Medicaid ICF-MR reimbursement rate).
- 13) Ensure that institutional funds that are reallocated to the community remain sufficient to support fully individuals' needs.
- 14) Refine the ICF-MR reimbursement method to more accurately reflect the level of acuity of individuals with developmental disabilities.
- 15) Explore the possibility of using the same Medicaid reimbursement formula for state and non-state ICFs-MR.
- 16) Instruct DHS to conduct an internal review of its current oversight methods designed to ensure that people with developmental disabilities are living in the "most integrated settings," as required by state and federal law.
- 17) Instruct DHS to create a task force composed of state center staff, ICF-MR staff, and other knowledgeable people as appropriate to develop a plan to adapt programs and environments within state centers and ICFs-MR to best meet the needs of an aging population.

## PROPOSALS NOT SUPPORTED BY MAJORITY OF THE WORKGROUP

The following proposals were considered, but were not supported by a majority, i.e., at least 8 members, of the Workgroup.

- 1) Expand community opportunities for residents at state DD Centers on weekends and holidays. (7 Ayes, 4 Nays, and 4 Abstain)
- 2) Place a moratorium on ICF-MR restructuring. (7 Ayes, 5 Nays, 3 Abstain)
- 3) Advocate for federal changes to allow self-directed waiver funds be used for ICFs-MR. (3 Ayes, 8 Nays, 4 Abstain)
- 4) Establish a Legislative Council Study committee to review the recommendations of this workgroup and investigate whether the long-term care system for individuals with developmental disabilities is adequate to meet the spectrum of needs. (5 Ayes, 6 Nays, 4 Abstain)

## CONCLUSION

The ICF-MR Committee has identified a package of recommendations to strengthen the long-term care system for individuals with developmental disabilities. Some of the recommendations require further legislative action because they involve a commitment of funds above the level of funding currently provided in the 09-11 biennial budget; specifically, recommendations 6, 12, and 15. Other recommendations could be implemented through a mix of legislative and administrative measures; specifically, recommendations 2, 5, 8, 9, and 13. The remaining recommendations do not require further legislative action for implementation. The Committee urges the Department of Health Services and the Legislature to give consideration to the Committee's recommendations in order to enhance the quality, access and choice of services in the long-term care system in Wisconsin for individuals with developmental disabilities.

Recommendation	Support	Support Comments	Oppose	Oppose Comments	Abstain	Abstain Comments
Ensure that institutional and community settings meet the safety, medical, personal, social, and spiritual needs of an individual in an environment that fosters a sense of belonging, meaningful interaction and continued growth.	15		0		0	
Expand specialized services, including short-term medical and behavioral services, mental services, crisis services, and respite services, to ensure these services are accessible statewide for individuals with developmental disabilities living in the community.	15	<p><b>Borreson</b> - I support the recommendation as I believe the recommendation was put forward to include ICF-MRs as a service provider in community settings throughout the State. <b>Egan</b> - Look into developing regional centers for this. <b>Ondrejka</b> - Combine this with #4. DHS will have to develop a marketing plan so people in the community are aware of these resources. <b>Sterling</b> - This was a key recommendation of the DD Coordinators in the southeast region years ago when the state first discussed closing SWC. The lack of these specialized services has contributed to many individuals returning to ICF-MR over the years. In addition, it may be beneficial within this proposal to allow center staff to follow people in the community for a more extended period of time than they have the ability to do now as part of the relocation process, particularly if a person has been a long term resident of the institution or has very specialized behavioral or medical needs.</p>	0		0	
1) Leverage existing ICF-MR staff expertise to expand expertise and capacity in the community, for example, by training providers in the community.	15	<p><b>Borreson</b> - Supports the premise that regional ICF-MRs would be of value throughout the State. <b>Bunck</b> - This is very important because there is a definite risk for losing considerable advanced expertise found in the ICFs. <b>Hart</b> - Provided that the cost of the service is reimbursed by the providers that are being trained. <b>Ondrejka</b> - This could include a train the trainer model.</p>	0		0	
4) Use staff and specialized services at the ICFs-MR, such as dental services, to serve individuals with developmental disabilities living in the community.	14	<p><b>Borreson</b> - Yes, as geographically appropriate. <b>Bunck</b> - Yes, however, this would be a capacity issue for the current number of Center dental staff. <b>Hart</b> - The cost of providing this service should be reimbursed to the ICF-MR. <b>Ondrejka</b> - Combine with #2.</p>	0		1	<b>Breedlove</b> - Need to know more specifics.
5) Ensure a capacity within the state for specialized long-term care for a period of time for people with developmental disabilities with complex medical acuity and behavioral and psychiatric needs.	13	<p><b>Bunck</b> - With the understanding that this should not be taken as a life-long commitment if new community capacity were to be developed. In the future long-term care should be thought of as changing to meet peoples needs as they mature, have changing health care needs, and changing interests in life based on developmental level, age, and life experiences. In other words, a continuum of choices over a lifetime. <b>Vinehout</b> - Please see the answer in #21 to see ideas on how to do this.</p>	1	<p><b>Bentley</b> - We shouldn't plan for people to be in institutions for many months or years. People should return to the community within 4 months. That should be enough time to develop the right supports. If there isn't a place that can meet the person's needs after 4 months, the person could continue to stay for 90 days at a time—until there is a place in the community to meet all the person's needs.</p>	1	<p><b>Ondrejka</b> - Depends - I would support developing the "capacity" for highly skilled, specialized supports in the community, but I think the recommendation referred to the State Centers.</p>

ATTACHMENT: ICF-MR COMMITTEE: RECORD OF VOTING AND COMMENTS ON PROPOSED RECOMMENDATIONS

12/10/2009

Recommendation	Support	Support Comments	Oppose	Oppose Comments	Abstain	Abstain Comments
6) Consider modernization of state DD Centers to reflect best practices and contemporary standards that are community-oriented.	10	<p><b>Bentley</b> - But, we have to build real homes with nice yards in communities around the state. I disagree with any housing built on the state institution grounds. I also disagree with building smaller institutions and calling them homes. <b>Borreson</b> - The DD State Centers need to be down sized with savings utilized to equalize ICF-MRs rates statewide. Right now State DD Centers are archaic and a "state of the art" modernization program would improve efficiencies and services. "Right sizing" of the State Centers is integral to preservation of the States remaining ICFs-MR and rate equalization based on acuity measures statewide. <b>Ondrejka</b> - Yes, but with the caveat that modernization of the Centers does not include "sprucing up" any existing buildings. It would be better to have homes around the state that could offer the same level of supports people receive at the Centers. <b>Underwood</b> - The highly specialized services for medically complex and medically fragile individuals, as currently exist at CWC, are not critical for some of our folks. These services are also a resource for community providers. To allow the dismantling of these services due to aging buildings would be a disservice to current and future generations. <b>Vinehout</b> - We can save money and keep people in the least restrictive environment by carefully analyzing the needs of the population at the state centers and creating a state-run facility that focuses on the needs of the most frail and complex patients and moving those who can thrive in a different type of facility. Of course we may need to create community resources that are not now available.</p>	3	<p><b>Hart</b> - This statement appears to indicate that the state DD centers are not using best practices and contemporary standards. <b>Loeber</b> - These are ICF-MR facilities that already modernized their facilities. Other states have gotten out of the state-run facility business. State-run facilities are not considered best practice.</p>	2	<p><b>Breedlove</b> - Need to know cost information to decide. <b>Groskopf</b> - Undecided without knowing cost impacts.</p>
7) Expand community opportunities for residents at state DD Centers on weekends and holidays.	7	<p><b>Anderson</b> - A new culture of thinking for all DD facilities that weekends and holidays are vital for community integration as are the weekdays. The Southern Wisconsin Center (SWC) does an excellent job with weekday community integration experiences. Let's see this carry over to the weekends and holidays without reason. A funding request (not at all) but a call for more enlightened thinking. A sincere initiative to further the quality of life of residents. <b>Bentley</b> - This doesn't have to be paid staff. Consider using more foster grandparents, Best Buddies, Americorps, and volunteers from churches. <b>Borreson</b> - This should be for all residential DD opportunities statewide. <b>Bunck</b> - This will require additional resources. <b>Sterling</b> - Will this be funded within the rate or how will these opportunities be funded?</p>	4	<p><b>Hart</b> - This statement gives the impressions that residents at state DD centers have nothing to do on weekends and holidays. I recommend that parents and guardians work with local parent groups and DD staff to voice their concerns. <b>Loeber</b> - This is an internal issue at the Centers. I feel this should not be part of the ICF committee recommendations. <b>Shilling</b> - This recommendation is too narrowly crafted and may result in unintended micromanaging of the state operated DD centers. Community activities must be looked at more closely based on resident needs, staff and budgetary restrictions, etc.</p>	4	<p><b>Groskopf</b> - Undecided without knowing cost impacts. (Agree with concept.) <b>Ondrejka</b> - Depends - I agree that people who live in ICF-MRs should have at least as many opportunities on weekends as they do during the week. I'm just not sure that this is in the purview of our committee. <b>Underwood</b> - Not within scope of Preservation Study. I suspect that community day service providers also operate on an M-F schedule, no weekends, no holidays so I don't feel this would be an issue encountered only at the State DD Centers. <b>Vinehout</b> - This is a matter of local management and one I would expect would be best left to the local administrators and their staff. If it is a resource issue the matter should be addressed through the budget process by the agency requesting additional staff.</p>
8) Ensure information on short-term ICF-MR programs is known as an option for people on waitlists.	14	<p><b>Loeber</b> - This is an issue for ADRC &amp; Family Care. This should easily be resolved. <b>Ondrejka</b> - Combine with #9. Stress that the resources are available short-term, until community-based services are available. It is unconscionable that families in crisis aren't given any options. Even a 30-day respite could be a tremendous help.</p>	0		1	<p><b>Groskopf</b> - Unsure of funding source &amp; would recommend technical assistance from DHS re: entire process.</p>

## ATTACHMENT: ICF-MR COMMITTEE: RECORD OF VOTING AND COMMENTS ON PROPOSED RECOMMENDATIONS

Recommendation	Support	Support Comments	Oppose	Oppose Comments	Abstain	Abstain Comments
Provide short-term support for individuals and families on waitlists.	14	Ondrejka - Combine with #8.	0		1	Groskopf - Unsure of funding source & would recommend technical assistance from DHS re: entire process.
3) Develop strategies for improving retention of community-based caregivers.	8	Bentley - This starts with increased wages and health care. Groskopf - Agree, as long as other programs/initiatives are collaborated with (workforce development grants, etc.). Sterling - Perhaps the state could provide a training program for community caregivers where specialized services are required. Now it falls on the community providers to develop and fund their own training programs. This can be costly. It also results in many agencies duplicating programs that may be better provided from a centralized entity. In addition, with the MA budget woes, providers in the Family Care system are being asked to do more with less as rates get adjusted statewide. With this comes their inability to pay a living wage to people who may otherwise want to make caregiving a real career choice. If there is any way the state could assist in the critical and often costly area of staff training, this would be a good thing for our most vulnerable people. There is historically a large amount of turnover of staff in these settings which is incredibly detrimental to residents. Perhaps with a more structured training system and support, this too could be reduced.	2	Borreson - Not part of this task force's focus. Hart - This statement appears to be directed to community based caregivers and is not connected to ICF-MRs. It would appear to be more of a comparison of benefits for employees at ICF-MR as compared to community based employee benefits.	5	Loeber - Does not know for a fact that their retention levels vary from the ICF's. Underwood - If retention is an issue, which it must be if it was mentioned, there must be another avenue for that to be addressed. Vinehout - This is a management issue for community facilities and is not related to the question of the future of ICF-MRs and the directions given the Task Force.
11) Establish a parent forum, composed of parents of individuals living in both institutional and community-based settings, as a way of sharing information about the service array available for people with developmental disabilities.	12	Loeber - Said 'yes' but is unclear as to with whom they would be sharing information.	1	Hart - This appears to be very broad based as services vary depending on the level of an individual's disability. The statement must include guardian's as many residents are not represented by a parent.	2	Underwood - Not within scope of Preservation Study but do see it as a good idea. Vinehout - This recommendation addresses problems that are beyond the scope of the Task Force and unrelated to the question of the future of ICF-MRs.
12) Undertake a rigorous study of mortality rates in Wisconsin for people with developmental disabilities in both institutional and community settings to understand the relative mortality and safety risks in both settings.	11		3	Borreson - Too many variables and scarce dollars in these times need to be directed to 'services'. Groskopf - Unsure of cost benefit ratio. Shilling - While this information might be helpful in better understanding the level of care for the developmentally disabled, it would seem extremely difficult to extract relevant data to accurately compare these settings side by side.	1	Vinehout - This recommendation may be needed but it is beyond the scope of the ICF-MR Preservation Task Force.

## ATTACHMENT: ICF-MR COMMITTEE: RECORD OF VOTING AND COMMENTS ON PROPOSED RECOMMENDATIONS

Recommendation	Support	Support Comments	Oppose	Oppose Comments	Abstain	Abstain Comments
j) Place a moratorium on ICF-MR restructuring.	7	<p><b>Anderson</b> - The voluntary placement initiative called for by Secretary Timbelake has been nothing short of debacle in reference to the SWC. The overwhelming majority of families and guardians at SWC have said the residents have a safe and secure campus at SWC. Both the health and quality of life of our loved ones takes priority over trends. <b>Borreson</b> - I believe we need to stop talking about restructuring, modernize State DD Centers (right size them) and use operational funds saved to fund existing ICF-MRs. We need a structure that will preserve regional ICF-MRs rather than following a policy of inadequate funding that assures the demise of Community ICF-MRs. <b>Loeber</b> - The state has achieved its desire to decrease ICF beds. Stop the process of the courts determining the most integrated setting to meet a persons needs. This has not proven to be effective and wastes the time of the courts. There would also be a savings of time and resources by not having to update the community plans every year. Most families/guardians are not choosing the ICF. The ICF-MR restructuring is not needed. Leave the process to the ADRC's and the Managed Care organizations. <b>Underwood</b> - Goal of restructuring (downsizing number of beds) must surely have happened by now. Time to re-evaluate goals of restructuring - unless restructuring actually meant elimination. A moratorium would also provide time to examine as to whether or not what consumers need actually exists outside of an institutional setting. Please see comments to #21. <b>Vinehout</b> - This statement cuts to the heart of why the task force was created. It is the first step to resolving the issues raised in the Legislature that led to the creation of the Task Force. The answer is an unequivocal YES. We must accept as policy that there are individuals that - some time in their lives - will need the services of ICF-MRs. Wisconsin must assure ICF-MRs are part of the spectrum of services available for DD clients.</p>	5	<p><b>Bove</b> - The ICF-MR initiative ensures that individuals with developmental disabilities have the choice to voluntarily relocate from ICFs-MR; and provides sufficient funding to support their community costs if they choose to do so. <b>Bunck</b> - I am not directly involved in county ICF-MR restructuring but I am involved with the Centers. I do believe that for economic, legal, and most importantly, consumer-choice reasons, this is the right time to rethink and re-engineer how Wisconsin views and supports the long-term care needs of people with intellectual disabilities.</p>	3	<p><b>Groskopf</b> - Cannot provide informed opinion. <b>Shilling</b> - Without a time frame for the moratorium or benchmarks for when it would be lifted, this recommendation is too broad. The ICF-MR restructuring process should continue to be closely examined and I agree that a long term vision for our care system should be clarified before major changes are made going forward. <b>Sterling</b> - Need more information before deciding.</p>

Recommendation	Support	Support Comments	Oppose	Oppose Comments	Abstain	Abstain Comments
1) Increase Medicaid reimbursement rate at non-state ICFs-MR (for example, by allocating funding that had previously been used for residents who die to increase the Medicaid ICF-MR reimbursement rate).	11	<p><b>Groskopf</b> - Agree, as long as impact to the overall Medicaid budget is cost neutral. <b>Loeber</b> - This is critical. ICF-MRs will continue to disappear.</p> <p><b>Underwood</b> - Under the ICF-MR Restructuring global pot of money, according to the Relocation Reports for the past 3 years, funds that become available when an ICF-MR resident dies can be and are being used to support the higher cost of individuals being relocated to non-institutional settings. My understanding of the global ICF-MR Restructuring budget is that the set amount of money designated by the Legislature must be used for the cost of new community relocations AND to manage the cost of serving individuals remaining in the institutions. There appears to be no prohibition on increasing reimbursement at non-state facilities - as long as the total spent stays within the global budget. <b>Vinehout</b> - We also discussed considering alternative funding methods to assure adequate funding for ICF-MRs. We discussed an 'adequacy model' of funding that would address the high fixed costs of institutional facilities.</p>	1	<b>Breedlove</b> - There would have to be a simultaneous increase in the CIP 1B rate. CIP 1B is more underfunded than ICF-MRs.	3	<b>Bove</b> - The Department must follow the direction in the 09-11 biennial budget bill regarding the level of Medicaid reimbursement for ICFs-MR. The Department can not make funding commitments for future biennia (i.e., the 11-13 biennium and beyond); these decisions will need to be made in the context of the development of the overall state 11-13 biennial budget and the fiscal constraints facing the state. <b>Ondrejka</b> - Depends - I agree with increasing MA reimbursement and equalizing rates for state and private ICFs (#18), but I think that parenthetical comment should be eliminated. <b>Shilling</b> - Would need more detailed information on the impact this might have on department wide Medicaid funding.
5) Ensure that institutional funds that are allocated to the community remain sufficient to support fully individuals' needs.	14	<b>Borreson</b> - Dollars need to follow the person. <b>Loeber</b> - This is critical. Community placement will not provide the most integrated settings. <b>Ondrejka</b> - Yes, but I believe this can be done within the existing structure of full funding for two years, with the funds rolled into the overall MCO rate after that. <b>Sterling</b> - As it stands now, MCOs get the actual cost of the community plan for members for a limited period of time. Is the intent of this to require the State to fully fund indefinitely?	0		1	<b>Groskopf</b> - Need further definition.
6) Advocate for federal changes to allow self-directed waiver funds be used for ICFs-MR.	3	<b>Buuck</b> - Especially if the ICF-MR services are specialized and tailored to specific individual needs and can change as a person's need and interests change over time.	8	<b>Bove</b> - The principle of self-direction is inconsistent with residing in an ICF-MR. <b>Breedlove</b> - CMS won't allow it, and the IRIS implementation committee hasn't concluded that the IRIS model could work in an ICF-MR. <b>Loeber</b> - Anyone who can self-direct their funds should not be living in an ICF-MR. If guardians want to do this, there are settings where this can work. <b>Shilling</b> - This issue should be looked into at greater length to determine the impact it may have before pursuing federal changes.	4	<b>Underwood</b> - If someone has the ability to self-direct then I am unclear as to why they would use ICF-MRs.
17) Refine the ICF-MR reimbursement method to more accurately reflect the level of acuity of individuals with developmental disabilities.	12	<b>Borreson</b> - DD 1a and DD 1b have long been the most acute care provided in an ICF-MR's. There are tremendous acuity differences within each level and dollars need to be direct to where they are most needed. <b>Vinehout</b> - It is a serious mistake to use only a functional or ADL assessment for ICF-MR clients. Adequate measures of acuity exist and they should be used.	0		3	<b>Ondrejka</b> - Maybe - I agree with the principle, but I'm not sure that acuity level is the best method for calculating rates.

ATTACHMENT: ICF-MR COMMITTEE: RECORD OF VOTING AND COMMENTS ON PROPOSED RECOMMENDATIONS

12/10/2009

Recommendation	Support	Support Comments	Oppose	Oppose Comments	Abstain	Abstain Comments
18) Explore the possibility of using the same Medicaid reimbursement formula for state and non-state ICFs-MR.	12	Egan - This is an absolute necessity. Underwood - Facility A should receive the same level of reimbursement as Facility B for identical services. The formula should have nothing to do with union or non-union employees or state or non-state facilities. The service provided and acuity level (#17) should be determining factors of reimbursement.	1	Breedlove - Their cost structure & the impact of the unions is very different.	2	Bove - Applying the same Medicaid reimbursement formula for state and non-state ICFs-MR will increase costs to the Medicaid program. The Department must follow the direction in the 09-11 biennial budget bill regarding the level of Medicaid reimbursement for ICFs-MR. The Department can not make funding commitments for future biennia (i.e., the 11-13 biennium and beyond); these decisions will need to be made in the context of the development of the overall state 11-13 biennial budget and the fiscal constraints facing the state.
19) Instruct DHS to conduct an internal review of its current oversight methods designed to ensure that people with developmental disabilities are living in the "most integrated settings," as required by state and federal law.	11	Sterling - I know there have been efforts over the years to improve the utilization review process.	1		3	Graskopf - Unsure of cost benefit ratio. Underwood - Only because any review of DHS oversight methods should be done by an independent, unbiased source - not DHS. Vinehout - The recommendation appears to be beyond the scope of the task force. It may be a useful and needed exercise.
20) Instruct DHS to create a task force composed of state center staff, ICF-MR staff, and other knowledgeable people as appropriate to develop a plan to adapt programs and environments within state centers and ICFs-MR to best meet the needs of an aging population.	14	Bentley - We need experts in aging to come up with a plan to support aging consumers in ICF-MRs and in the community. Bunck - People with intellectual disabilities are, in many instances, now living as long as everyone else. Hart - Every resident of a state center completes an annual WATTS review. During this review the court determines that an individual is living in the "most integrated" setting. Are people living in the community required to have an annual review to determine if placement in the community is the "most integrated"? Would the option of being placed at a state DD center be available? Ondrejka - This effort should be expanded to other settings. All providers have to learn how to support people with DD as they age. Sterling - Please address the issue of active treatment. I have felt for years that elderly people that have a developmental disability have been treated unfairly in their golden years. When in their lives can they just be elders and not placed in measured? Vinehout - Although the best venue may be an effort organized by industry groups and DHS, not spearheaded by DHS alone.	0		1	Underwood - Only because DHS should not be in charge of this, not because it is not needed. The needs of the aging DD population should absolutely be addressed.

Recommendation	Support	Support Comments	Oppose	Oppose Comments	Abstain	Abstain Comments
1) Establish a Legislative Council Study Committee to review the recommendations of the workgroup and investigate whether the long-term care system for individuals with developmental disabilities is adequate to meet the spectrum of needs.	5	Egan - This might ensure that all of the Committee's work will be taken under consideration. Loeber - This is necessary to make sure these recommendations are moved forward.	6	Anderson - Let us move forward with many of the excellent recommendations made here. Borreson - I suggest that for now a Legislative Council Committee not be requested and only if DHS does not follow on this committee's recommendations should a study be requested. I would rather ask the DHS Secretary to name this Committee or like Committee to prepare implementation plans for this Committee's recommendations. Bove - A Legislative Council Study is not needed to review the recommendations of this workgroup. A Leg. Council Study of the adequacy of the long-term care system for individuals with developmental disabilities would be duplicative of the work completed by this workgroup. Shilling - This may be duplicative of the work that has already been done and would delay the implementation of this committee's recommendations. Vinehout - The recommendations I have agreed to above can be implemented by DHS without a Legislative Council study. A study will only slow the process. There was a much larger question raised by the Task Force that would be of interest to the Legislature and should be recommended to Legislative Council for a study. That question was addressed in #6 above. The role of the state centers in serving the ICF-MR population should be addressed. Can we provide care to some individuals in the state centers in a least restrictive environment? Can we create a "right size" state facilities in Wisconsin that address the needs of individuals that are the most frail and have the most complex medical conditions while providing care for others in a different type of facility? Perhaps we need a long range plan for the State Commission. A way to address several of the budget and policy problems the state now faces - high mandatory overtime at the state facilities; evidence of chronic understaffing; high turnover; aging, high maintenance, high cost facilities that are now inadequate to address the changing needs of the population. Can we create two smaller, state of the art facilities that address the needs of the a mission to serve - the most complex, frail individuals in our state?	4	Runck - It would seem that if the previous 20 items move forward, this would not be necessary. If not, my vote would be 'yes'. Underwood - Yes and No - a legislative council study may only delay the process and not address critical funding issues as rapidly as needed. However, a council study would provide an expanded opportunity, not provided for in our short timeframe, to examine what other states are doing. Example: CA has created by legislative act, a pilot project for Adult Residential Facilities for Persons with Special Health Care Needs. This pilot project was developed to address the special health care needs of individuals impacted by the closure of a state DD facility. The requirements for operation of these facilities and who can utilize these services is all spelled out in law. They are not ICFs/MR. They are far superior to the adult family home that our medically fragile folks have as an option. Maximum number of residents per facility is 5. Law is very specific as to who can administer these facilities and training requirements. Notable requirements is license LPN, or licensed psychiatric technician is awake and on duty 24/7. As Senator Vinehout commented, what is needed may not currently exist. A Leg Council Study could examine in more detail a variety of options and service models.

Committee Members Voting	
Steven Anderson	Ted Bunck
Cindy Bentley	Cathy Egan
Phil Borreson	Gina Groskopf
Fredi-Ellen Bove	Harold Hanc
Lynn Breadlove	Ardis Loeber
	Jennifer Ondrejka
	Jennifer Shilling
	Kim Sterling
	Rebecca Underwood
	Kathleen Vinehout

## Appendix A: Committee Membership

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Fredi Bove, Chair	Deputy Division Administrator Division of Long Term Care
Steve Anderson	Brother of SWC Resident
Cindy Bentley Supported by: Mary Clare Carlson	Former SWC Resident Staff member of People First
Phil Borreson	Director Trempealeau County Health Care Center
Lynn Breedlove	Executive Director Disability Rights Wisconsin
Ted Bunck	Director, Central Wisconsin Center Director, Bureau of Center Operations
Cathy Egan	Parent of Bethesda ICF-MR Resident
Gina Groskopf	Care Wisconsin Family Care Managed Care Organization
Hal Hart	President CWC Parents Committee
Ardis Loeber	Director Bethesda Lutheran ICF-MR
Jennifer Ondrejka	Executive Director WI Board for People with Developmental Disabilities
Kim Sterling	Southwest Family Care Alliance Family Care Managed Care Organization
Kevin Underwood	President Wisconsin Parents Coalition for the Retarded and CWC Parent
Jennifer Shilling	Member of State Assembly

Kathleen Vinehout

Member of State Senate

Michael Pancook

Staff, Office of Policy Initiatives and Budget

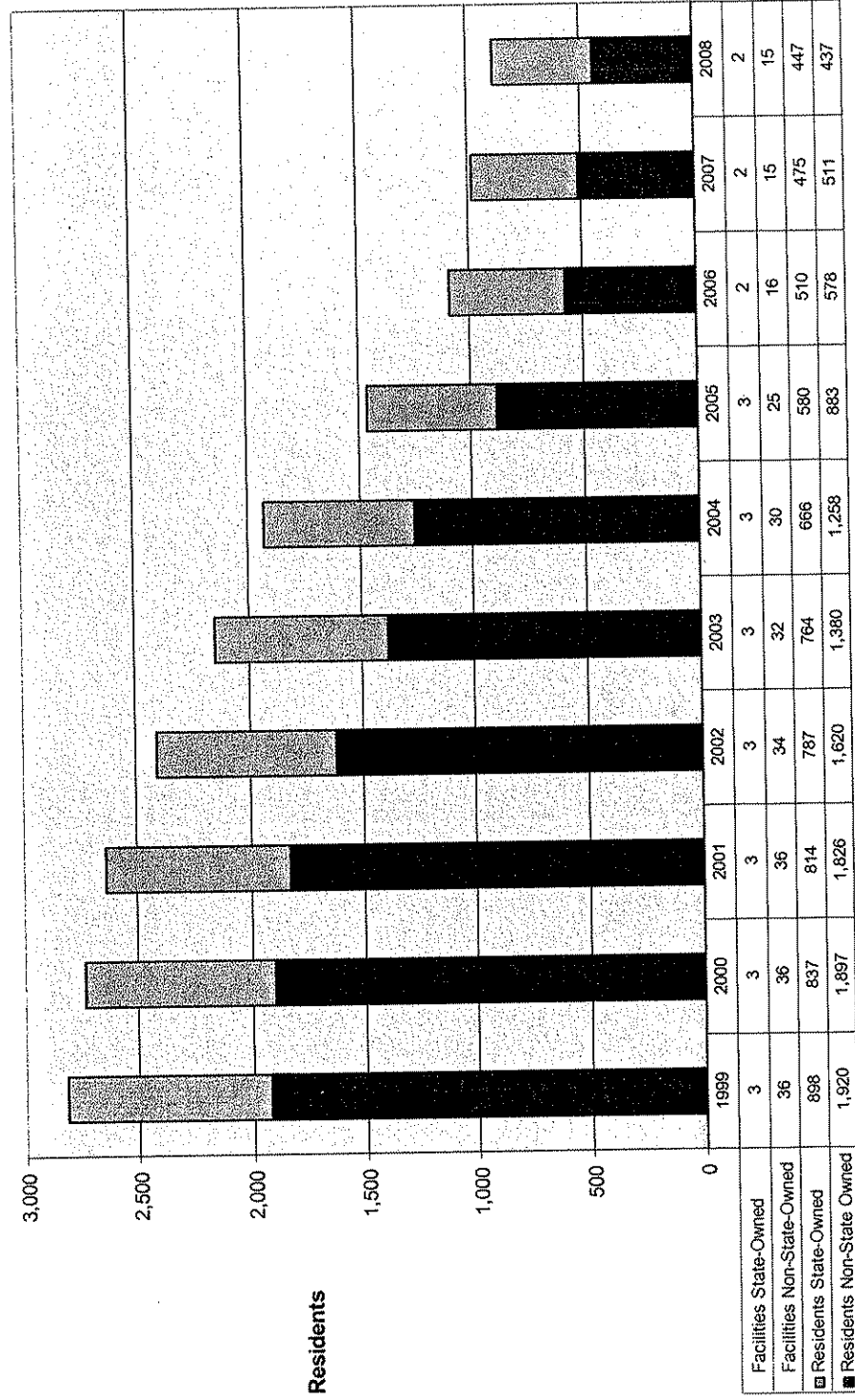
# Appendix B: Residents with Developmental Disabilities, Bed Capacity, and Location by Facility

Facility	Residents (Dec 31, 2008 or as noted)	Beds (Aug 2009)	County
<b>Private and County ICFs-MR</b>			
Bethesda Lutheran Home	114	120	Jefferson
Clark County HCC	22	28	Clark
Clearview South	52	53	Dodge
Lakeview HCC	13	14	LaCrosse
McCarthy Nursing Home	12	12	Dane
Milwaukee County MHC	56	72	Milwaukee
Nonwood Health Center	9	9	Wood
Orchard Manor	29	35	Grant
Rolling Hills Rehab Center	10	14	Monroe
Racine Residential Care (planning to close by 12/31/09)	23 (Sept 15, 2009)	29	Racine
Sheltered Village of Ripon	31	50	Fond Du Lac
St. Coletta of Wisconsin Inc - Alverno (planning to close by 9/30/10 or earlier)	16 (Aug 31, 2009)	16	Jefferson
Trempealeau County HCC*	12	11	Trempealeau
<b>State Centers (excludes short-term residents)</b>			
Northern Wisconsin Center	0	30	Chippewa
Central Wisconsin Center	257	340	Dane
Southern Wisconsin Center	184	210	Racine

**Total Number of ICFs-MR Serving Long-Term Residents: 15**

\* Trempealeau County HCC reported 12 beds in December 2008

# Appendix C Trend in Wisconsin Medicaid ICF-MR Residents



\* State-owned facility resident count in 2006 and 2007 exclude short-term Intensive Treatment Program residents

\*\* Northern Wisconsin Center ended its long-term care program in September 2006.

**Appendix D: Age Information for Residents with Developmental Disabilities (December 2008)**

<b>Private/County ICFs-MR</b>	<b>Residents</b>	<b>Average Age</b>	<b>Minimum Age</b>	<b>Maximum Age</b>
Bethesda Lutheran Home	126	50	9	93
Clark County HCC	24	65	26	97
Clearview South	52	58	20	91
Lakeview HCC	11	56	40	71
McCarthy Nursing Home	12	54	30	79
Milwaukee County MHC	63	40	19	69
Norwood Health Center	9	36	20	56
Orchard Manor	32	57	32	81
Rolling Hills Rehab Center	12	54	20	86
Racine Residential Care	38	57	21	85
Sheltered Village of Ripon	33	57	32	84
St. Coletta of Wisconsin Inc - Alverno	37	62	26	90
Trempealeau County HCC	13	35	22	56
<i>All ICF-MR Residents</i>	462	53	9	97
<b>State Centers (excludes short-term service recipients)</b>				
Northern Wisconsin Center	N/A	N/A	N/A	N/A
Central Wisconsin Center	257	45	12	94
Southern Wisconsin Center	184	53	34	83
<b>Skilled Nursing Facilities</b>				
All Residents with Developmental Disabilities	62	60	23	88

**Appendix E: Deaths and New Long-Term Care Admissions for State-Owned and Non-State ICFs-MR**

	2005	2006	2007	2008
<b>Deaths</b>				
Non-State ICFs-MR	66	58	36	29
State Centers	13	9	9	7
<b>New Long-Term Care Admissions*</b>				
Non-State ICFs-MR	40	26	31	21
State Centers	0	0	0	0
<b>Average Age of New Admissions</b>				
Non-State ICFs-MR	42	43	48	44
State Centers	N/A	N/A	N/A	N/A
<b>New Admissions by ICF-MR Existing Facilities</b>				
Bethesda Lutheran Home	5	1	0	2
Clark County HCC	3	5	5	2
Clearview South	1	4	4	1
Lakeview HCC	1	2	4	2
McCarthy Nursing Home	1	0	1	1
Milwaukee County MHC	9	3	5	4
Norwood Health Center	1	0	1	0
Orchard Manor	0	4	1	3
Rolling Hills Rehab Center	2	1	2	4
Racine Residential Care	4	1	1	0
Sheltered Village of Ripon	1	1	4	2
St. Coletta of Wisconsin Inc - Alverno	1	2	1	0
Trempealeau County HCC	5	2	2	0

**New Admissions by ICF-MR (cont.)**

<i>Former Facilities</i>	2005	2006	2007	2008
Brown County Bayview	1	0	0	0
Dunn County	2	0	0	0
Eagleton	1	0	0	0
Rock County	1	0	0	0
Sauk County	1	0	0	0

\* Admission date is defined as first date of service in an ICF-MR based on Medicaid claims data. Short-term stays (less than 91 consecutive days of service) excluded. Data available from October 2004 forward; individuals residing and exiting an ICF-MR prior to October 2004 and re-entering an ICF-MR in January 2005 or later will appear as new admissions in this analysis.

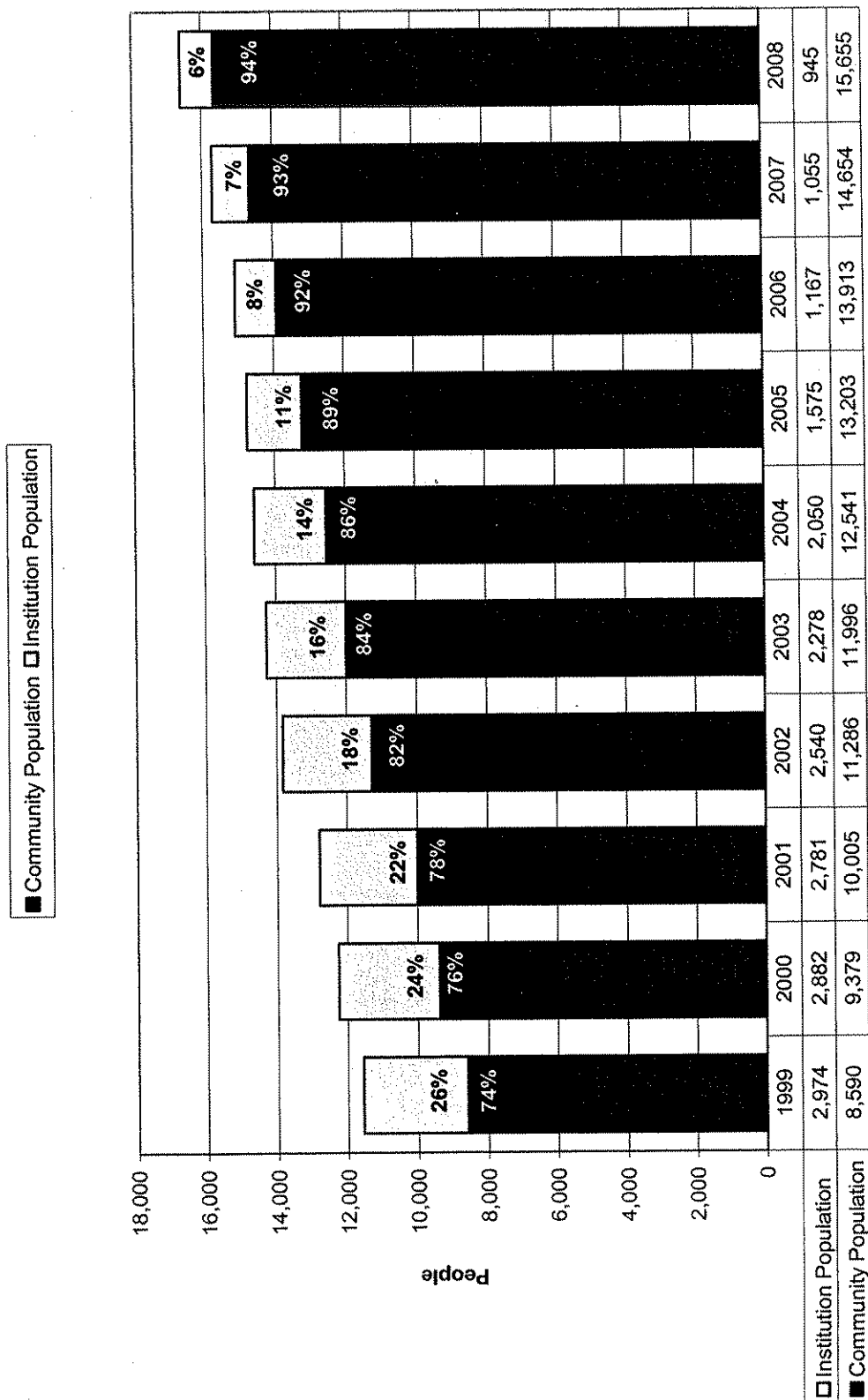
**Appendix F: Long Term Care Institutions for People with Developmental Disabilities**

	Number of Institutions			Institutions by Size		
	State Centers	ICFs-MR	Total	1-6 beds	7-15 beds	16+ beds
US	334	6,075	6,409	3,691	2,115	603
WI	2	15	17	0	4	13
AL	1	4	5	0	4	1
AK	0	0	0	0	0	0
AZ	5	1	6	0	4	2
AR	6	35	41	0	31	10
CA	7	1,116	1,123	1,105	0	18
CO	2	4	6	4	0	2
CT	7	68	75	64	4	7
DE	1	1	2	0	0	2
DC	0	118	118	94	24	0
FL	6	87	93	38	2	53
GA	5	1	6	0	0	6
HI	0	17	17	17	0	0
ID	1	54	55	27	27	1
IL	9	303	312	42	221	49
IN	3	530	533	201	326	6
IA	2	132	134	68	43	23
KS	2	27	29	15	10	4
KY	5	4	9	0	3	6
LA	39	474	513	340	155	18
ME	1	25	26	10	15	1
MD	4	0	4	0	0	4
MA	6	0	6	0	0	6
MI	1	0	1	0	0	1
MN	16	275	291	157	97	37
MS	68	5	73	1	62	10
MO	9	7	16	2	4	10
MT	1	0	1	0	0	1
NE	1	3	4	0	1	3
NV	2	7	9	6	0	3
NH	0	1	1	0	0	1
NJ	7	2	9	0	0	9
NM	1	27	28	14	14	0
NY	52	528	580	65	447	68
NC	4	315	319	273	29	17
ND	1	63	64	24	38	2
OH	10	399	409	92	232	85
OK	2	84	86	37	21	28
OR	1	0	1	0	0	1
PA	5	198	203	130	49	24

	Number of Institutions			Institutions by Size		
	State Centers	ICFs-MR	Total	1-6 beds	7-15 beds	16+ beds
RI	4	1	5	4	0	1
SC	5	80	85	3	77	5
SD	1	0	1	0	0	1
TN	3	80	83	28	49	6
TX	15	868	883	794	58	31
UT	1	14	15	0	2	13
VT	0	1	1	1	0	0
VA	5	30	35	14	14	7
WA	4	8	12	6	2	4
WV	0	63	63	15	46	2
WY	1	0	1	0	0	1

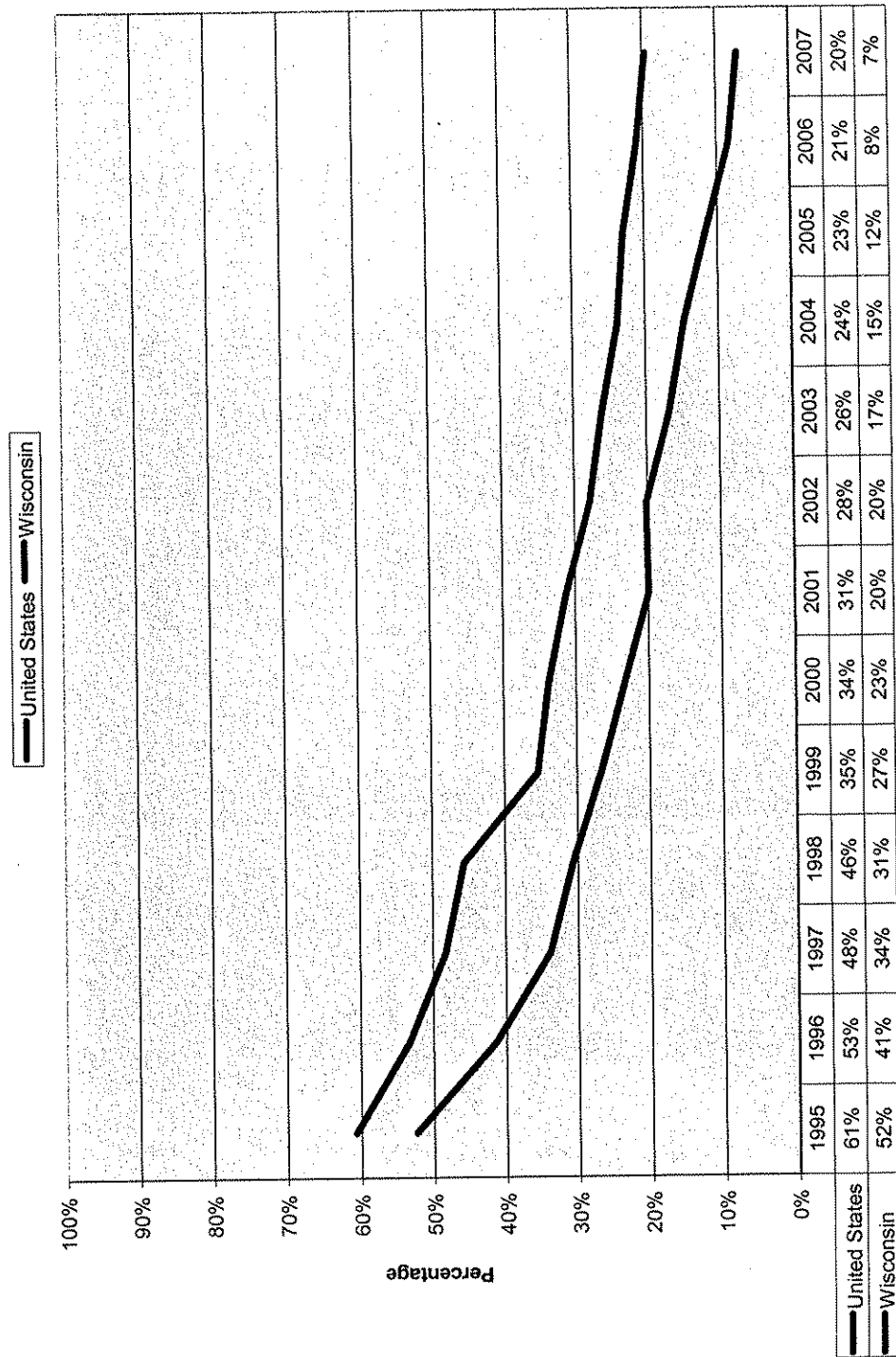
Source: *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007*; College of Education and Human Development, University of Minnesota; August 2008, p. 60

**Appendix G: People with Developmental Disabilities in Publicly-Funded Long-Term Care Programs (year end totals)**



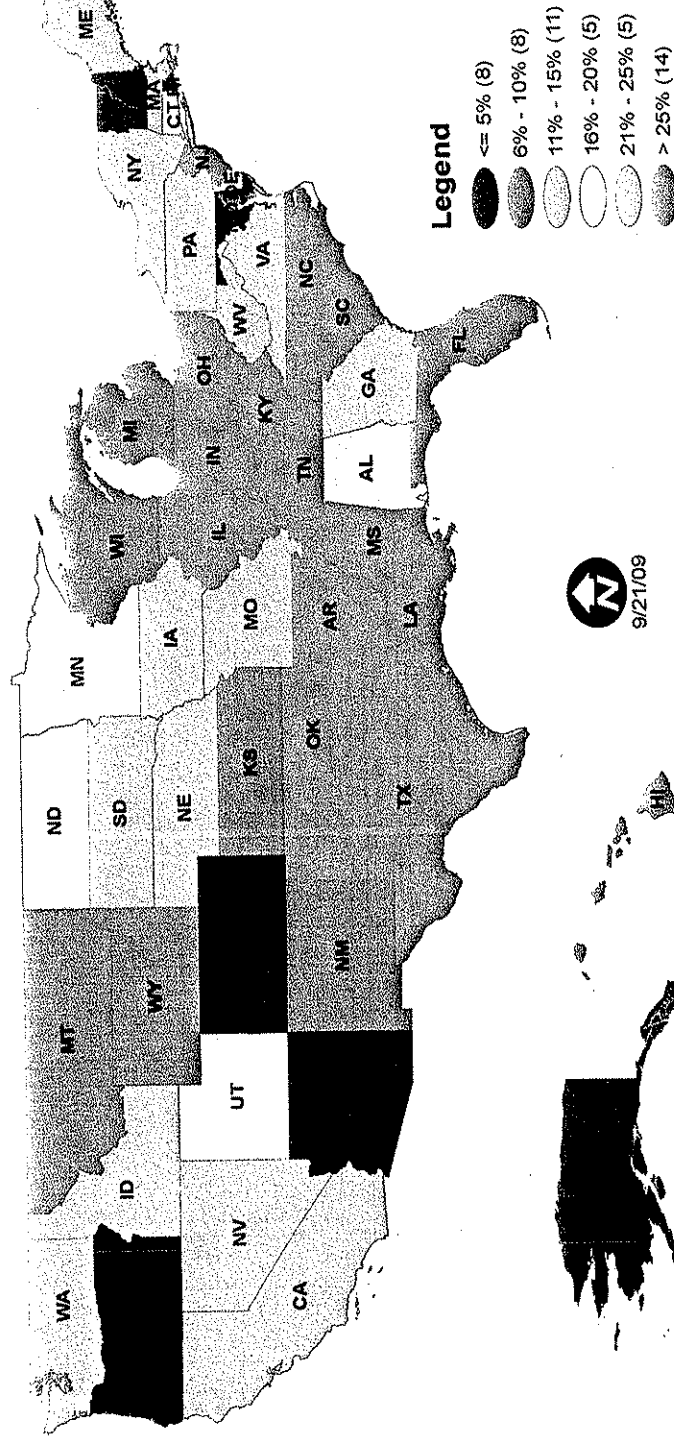
\* Community population includes participants in waiver programs, Family Care, and PACE/Partnership  
 \* Institution population includes residents in ICFs-MR, State Centers for the Developmentally Disabled, and individuals with developmental disabilities in skilled nursing facilities

**Appendix H: Percentage of People with Developmental Disabilities in Institutional Settings: United States and Wisconsin**  
*(June 30<sup>th</sup> populations)*



# Appendix I: Percentage of Persons with Developmental Disabilities Residing in Community or Institutional Settings

## Percentage of Persons with Developmental Disabilities Residing in an Institution (June 30, 2007)



Data Source:  
Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007;  
College of Education and Human Development, University of Minnesota; August 2008

Map Created By:  
Aron West, GIS Analyst, 603-267-2360  
WI Dept. of Health Services



**Percentage of Persons with Developmental Disabilities Residing in Community or Institutional Settings**

	<i>Served in the Community</i>	<i>Reside in an Institution</i>
US	80%	20%
Mean State	82%	18%
Median State	87%	13%
WI	93%	7%
AL	82%	18%
AK	99%	1%
AZ	99%	1%
AR	56%	44%
CA	87%	13%
CO	97%	3%
CT	83%	17%
DE	79%	21%
DC	63%	37%
FL	90%	10%
GA	78%	22%
HI	93%	7%
ID	75%	25%
IL	57%	43%
IN	64%	36%
IA	86%	14%
KS	92%	8%
KY	73%	27%
LA	54%	46%
ME	89%	11%
MD	97%	3%
MA	87%	13%
MI	90%	10%
MN	84%	16%
MS	41%	59%
MO	89%	11%
MT	90%	10%
NE	78%	22%
NV	87%	13%
NH	96%	4%
NJ	73%	27%
NM	93%	7%
NY	88%	12%
NC	67%	33%
ND	84%	16%
OH	71%	29%
OK	71%	29%
OR	99%	1%

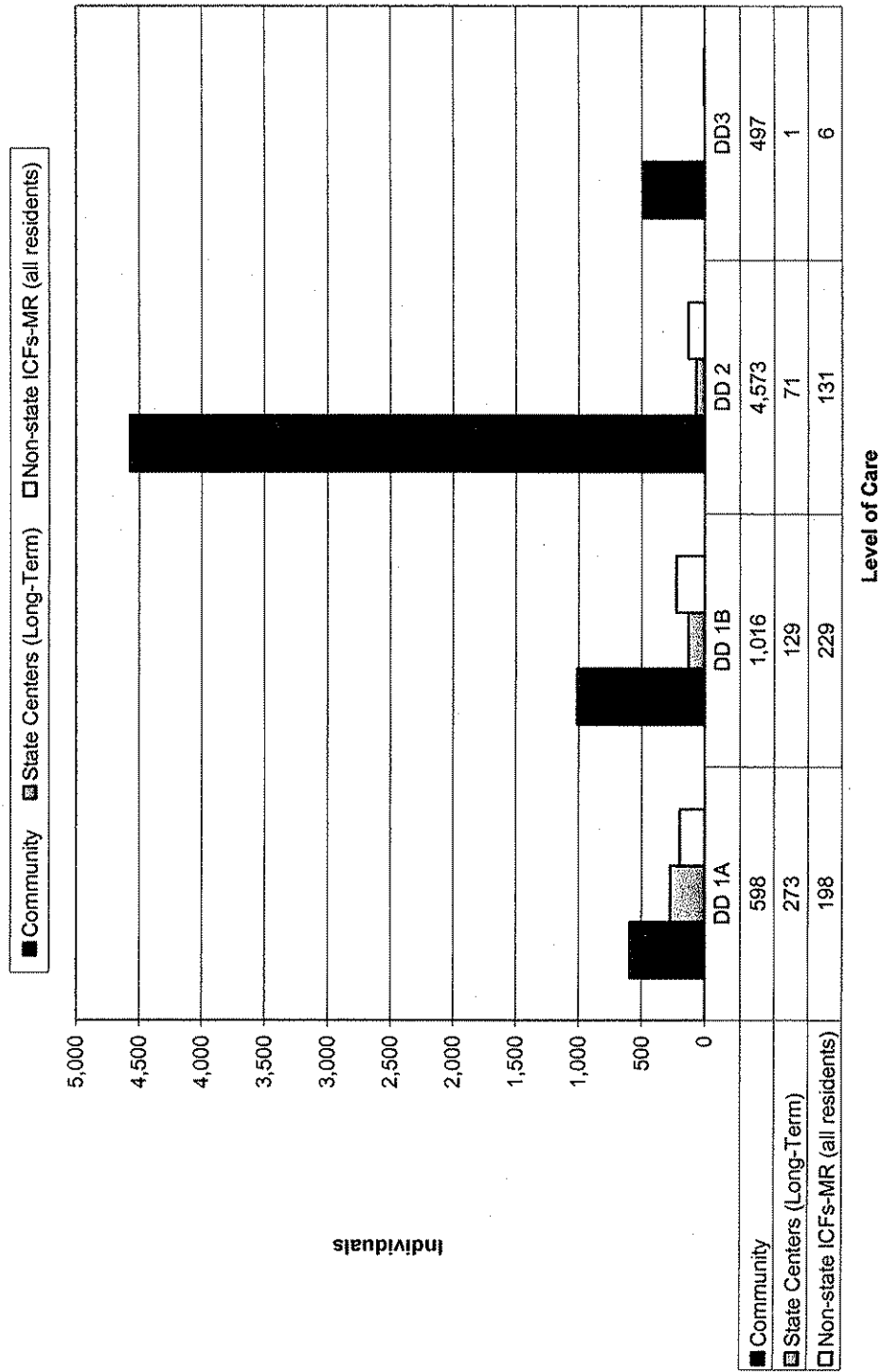
	<i>Served in the Community</i>	<i>Reside in an Institution</i>
PA	87%	13%
RI	96%	4%
SC	74%	26%
SD	89%	11%
TN	73%	27%
TX	59%	41%
UT	81%	19%
VT	99%	1%
VA	76%	24%
WA	89%	11%
WV	89%	11%
WY	94%	6%

Institutional population includes residents of state centers, non-state ICFs-MR, and individuals with developmental disabilities in skilled nursing facilities.

Source: *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007*; College of Education and Human Development, University of Minnesota; August 2008, state appendices

Wisconsin information was adjusted from the information in *Residential Services for Persons with Developmental Disabilities*. Data from the state Medicaid claims database was substituted for the number of individuals with developmental disabilities in a skilled nursing facility. Members of Family Care, Family Care Partnership, and PACE were added to the number of individuals served in the community.

# Appendix J: Individuals with Developmental Disabilities by Level of Care: Institutional and Community Settings (2008)



Note: Community members include Family Care and PACE/Partnership members from December 2008. State Center and ICF-MR residents include residents during CY 2008.

Appendix K: ICF-MR Medicaid Fee-For-Service Deficits Per Patient Day by Type of Ownership (2008/2009 Rate Year)

		County*				Centers		
Number of Facilities		8	3	2	13	3		
Direct Care	MA Allowable Costs	247.62	158.07	104.97	193.61	393.83		
	Revenue Deficit	146.10 (101.52)	123.84 (34.23)	105.08 0.11	132.17 (61.44)			
Support Services	MA Allowable Costs	101.03	100.49	42.97	95.55	154.60		
	Revenue Deficit	42.00 (59.03)	42.00 (58.49)	42.00 (0.97)	42.00 (53.55)			
Other	Bed Assessment Cost	23.08	25.67	24.40	24.39	20.14		
	Other MA Allowable Costs	7.89	28.65	1.19	16.82	105.54		
	Other Revenue Deficit	32.23 1.25	42.12 (12.21)	29.03 3.44	36.48 (4.73)	- -		
Supplement and CPE Revenue		33.61	-	-	15.14	-		
Total MA Allowable Costs		379.63	312.88	173.54	330.37	674.11		
Total Revenues		253.93	207.96	176.11	225.79	-		
Total Deficit		(125.70)	(104.93)	2.57	(104.58)	-		

\* County cost per patient estimated based on case mix indices as county cost reports combine costs from skilled nursing facilities and ICF-MRs

source: Non-State Centers: 2007 Cost Reports & 2008 / 2009 Rate Formula; State Centers: FY 2008 Allowable Costs

**Appendix L: County Support for CIP Waivers**

<b>County Funding for CIP Waivers</b>			
	<b>2006</b>	<b>2007</b>	<b>2008</b>
<i>CIP 1A</i>			
County Funding	\$7,271,636	\$7,176,951	\$5,453,056
Proportion of Total Funding	8%	8%	7%
<i>CIP 1B</i>			
County Funding	\$88,910,758	\$91,857,056	\$78,571,823
Proportion of Total Funding	35%	34%	31%
<i>CIP 1A and 1B</i>			
County Funding	\$96,182,394	\$99,034,007	\$84,024,879
Proportion of Total Funding	28%	28%	26%
<b>County-Funded CIP 1B Waiver Slots</b>			
	<b>12/31/2006</b>	<b>12/31/2007</b>	<b>12/31/2008</b>
Number of County-Funded Slots	7,253	7,282	5,222
Proportion of CIP 1B Slots	68%	68%	67%
			3,901
			67%

**Appendix M: Average Daily Cost/Medicaid Payment for Individuals with Developmental Disabilities Who Relocated to the Community**

	Institute/Waiver	Patient Liability Payment	MA Card	Total
State Center Long-Term Care Resident Cost and MA Payment (CY 08)	\$639	\$20	\$8	\$666
Cost of ICF-MR Resident (CY 08)	\$330		\$11 <sup>1</sup>	\$341
Waiver Participants who Relocated from ICFs-MR (FY 08)	\$205		\$55	\$260
Payment for Individuals in an ICF-MR Prior to Relocation (FY 08)	\$177	\$15	\$10	\$203

**Footnote:**

<sup>1</sup> Estimate based on card costs for ICF-MR residents in FY 08

**sources:**

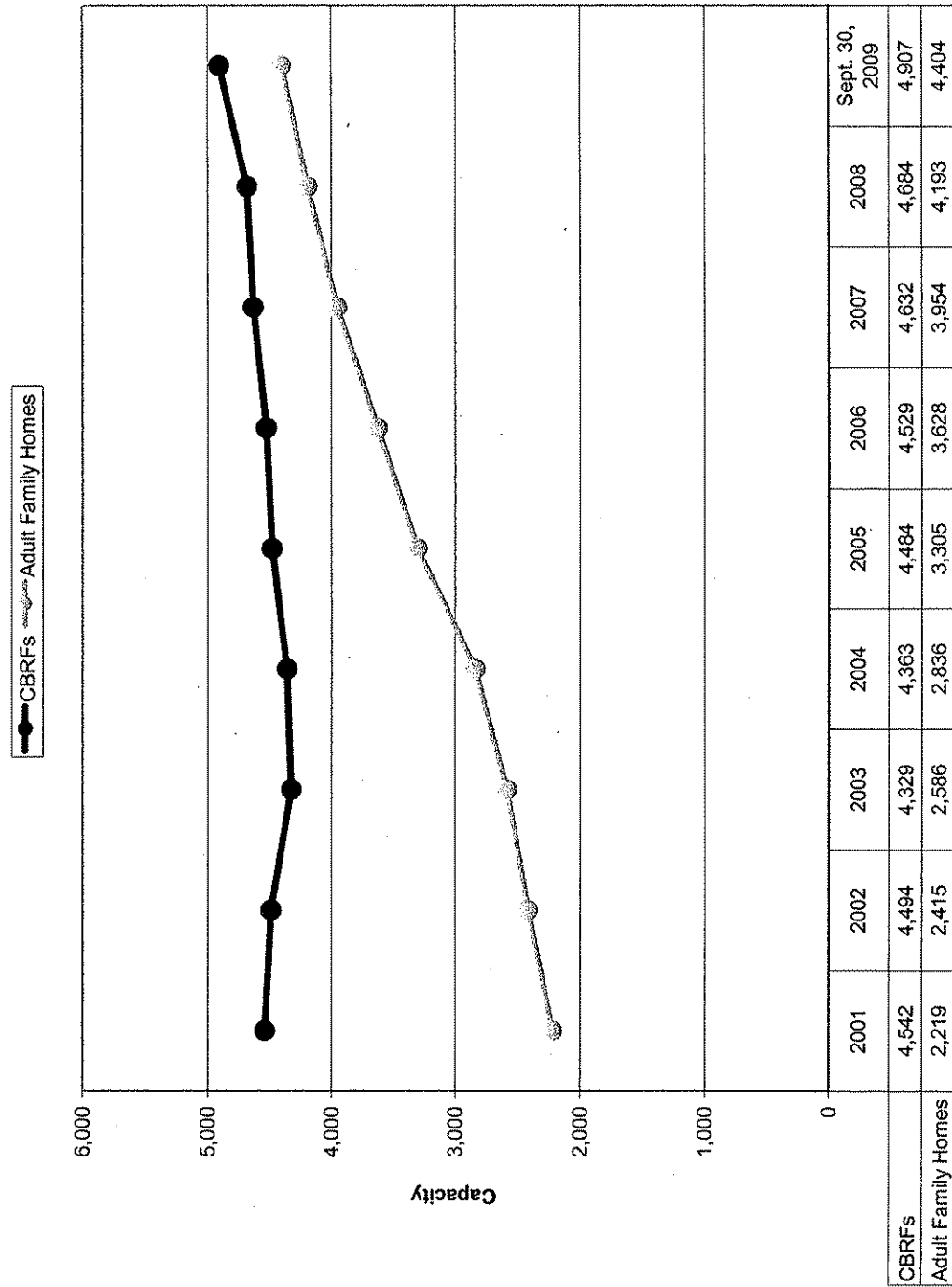
State Center: MA Claims database

ICF-MR Costs: 2007 Cost Reports & 2008 / 2009 Rate Formula

Waiver, ICF-MR: *SFY 2008 Report on Relocations and Diversions from Institutes*

Patient Liability based on historic information on patient liability payments compared to state payments

**Appendix N: Capacity of Assisted Living Facilities Serving People with Developmental Disabilities**  
*(December 31<sup>st</sup> unless otherwise noted)*



**Appendix O: Intensive Treatment Programs at State Centers:  
Levels of Care and Lengths of Stay for Annual Discharges**

		2005	2006	2007	2008	2009
<b>ITP Patients by DD Care Level</b>						
Central Wisconsin Center						
	DD1A	0	0	0	0	0
	DD1B	33	27	43	22	16
	DD2	0	0	0	0	0
	DD3	0	0	0	0	0
Northern Wisconsin Center						
	DD1A	0	0	0	3	2
	DD1B	9	28	51	38	27
	DD2	0	0	1	1	0
	DD3	0	1	0	0	0
Southern Wisconsin Center						
	DD1A	3	1	0	0	1
	DD1B	9	14	18	7	4
	DD2	1	0	1	0	0
	DD3	0	0	0	0	0
<i>All State Centers</i>						
	DD1A	3	1	0	3	3
	DD1B	51	69	112	67	47
	DD2	1	0	2	1	0
	DD3	0	1	0	0	0
<b>Lengths of Stay in ITP Units (days)</b>						
Central Wisconsin Center						
	Patients	33	27	43	22	16
	Median LOS	28	28	28	28	28
Northern Wisconsin Center						
	Patients	9	29	52	42	29
	Median LOS	99	98	92	102.5	115
Southern Wisconsin Center						
	Patients	13	15	19	7	5
	Median LOS	147	306	105	87	202

**Notes:**

\* 2009 length of stay data excludes patients still receiving ITP services as of 10/26/2009

All state center data includes patients who may have switched to Family Care

Source: Insight Database

**Appendix P: Use of Institutions in Managed Long-Term Care Programs for Members with Developmental Disabilities**  
*(based on members enrolled on 12/31/2008)*

	<b>Members with Institution Stays in CY 2008</b>	<b>Members in an Institution 12/31/2008 Number</b>	<b>Pct. of Members with DD</b>
<b>Family Care</b>			
ICF-MR	14	6	0.1%
State Center	13	5	0.1%
<i>Total</i>	27	11	0.2%
<b>PACE/Partnership</b>			
ICF-MR	0	0	0.0%
State Center	0	0	0.0%
<i>Total</i>	0	0	0.0%

Note:  
 PACE/Partnership began enrolling individuals with developmental disabilities in 2008, which leads to a smaller sample to analyze